Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IN005269	A. BUILDING: _____ B. WING _____	C 03/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOOSIER UPLANDS HOME HEALTH CARE	500 W MAIN ST MITCHELL, IN 47446

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments This was a home health state complaint investigation survey. Complaint #: IN00124366- Substantiated: No deficiencies related to allegation are cited. Survey date: 3/11-14, 2013 Facility #: 005269 Medicaid Vendor: 100272810A Surveyor: Dawn Snider, RN, PHNS Hoosier Uplands Home Health Care was found to be in compliance with the Indiana rules for home health agency licensure 410 IAC Article 17 Rule 14 Section 1 as related to this complaint. Quality Review: Joyce Elder, MSN, BSN, RN March 22, 2013	N 000		